FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027680

Facility Name: SHERIDAN HEALTH CARE CENTER

Address: 2534 ELIM AVENUE (Number) ZION (City) 60099 (Zip Code)

County: LAKE

Telephone Number: (847) 746-8435 **Fax #** (847) 746-1744

IDPA ID Number: 363194993001

Date of Initial License for Current Owners: 10/10/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) GARRY S. CHANKIN, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/1/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3	192	Intermediate (ICF)	174	67,578	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	288	TOTALS	270	102,618	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	353		4,101	4,454	8
9	SNF/PED					9
10	ICF	64,627	5,165	2,610	72,402	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,980	5,165	6,711	76,856	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.90%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
ADULT DAY CARE AND MEALS ON WHEELS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 3,269

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	317,544	43,395	10,196	371,135		371,135		371,135			1
2	Food Purchase		383,714		383,714		383,714	(257)	383,457			2
3	Housekeeping	304,385	55,736		360,121		360,121		360,121			3
4	Laundry	173,239	57,126	5,451	235,816		235,816		235,816			4
5	Heat and Other Utilities			201,578	201,578		201,578		201,578			5
6	Maintenance	208,362	26,085	102,648	337,095		337,095	(32,189)	304,906			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,003,530	566,056	319,873	1,889,459		1,889,459	(32,446)	1,857,013			8
	B. Health Care and Programs											
9	Medical Director			18,526	18,526		18,526		18,526			9
10	Nursing and Medical Records	2,712,875	149,147	42,210	2,904,232		2,904,232	(3,943)	2,900,289			10
10a	Therapy	86,152	5,427	26,651	118,230		118,230		118,230			10a
11	Activities	105,848	21,337	1,548	128,733		128,733		128,733			11
12	Social Services	413,428	2,141	6,146	421,715		421,715		421,715			12
13	Nurse Aide Training	28,737	1,431	650	30,818		30,818		30,818			13
14	Program Transportation			3,858	3,858		3,858		3,858			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,347,040	179,483	99,589	3,626,112		3,626,112	(3,943)	3,622,169			16
	C. General Administration											
17	Administrative	169,760		471,500	641,260		641,260	(298,937)	342,323			17
18	Directors Fees											18
19	Professional Services			86,879	86,879		86,879		86,879			19
20	Dues, Fees, Subscriptions & Promotions			76,982	76,982		76,982	(48,878)	28,104			20
21	Clerical & General Office Expenses	176,078	5,421	159,164	340,663		340,663	(50,905)	289,758			21
22	Employee Benefits & Payroll Taxes			724,505	724,505		724,505	(3,521)	720,984			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,999	4,999		4,999	(481)	4,518			24
25	Other Admin. Staff Transportation			629	629		629		629			25
26	Insurance-Prop.Liab.Malpractice			154,381	154,381		154,381		154,381			26
27	Other (specify):*							3,713	3,713			27
28	**TOTAL General Administration**	345,838	5,421	1,679,039	2,030,298		2,030,298	(399,010)	1,631,288			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,696,408	750,960	2,098,501	7,545,869		7,545,869	(435,399)	7,110,470			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER #0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			376,994	376,994		376,994	(55,843)	321,151			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			266,745	266,745		266,745	(30,626)	236,119			32
33	Real Estate Taxes			218,807	218,807		218,807		218,807			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			36,966	36,966		36,966		36,966			35
36	Other (specify):*			6,373	6,373		6,373	(6,373)				36
37	**TOTAL Ownership**			905,885	905,885		905,885	(92,842)	813,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		230,121	194,432	424,553		424,553	(11,875)	412,678			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,846	5,846		5,846	(5,846)				41
42	Provider Participation Fee			153,927	153,927		153,927		153,927			42
43	Other (specify):*	131,067		3,959	135,026		135,026	(135,026)				43
44	**TOTAL Special Cost Centers**	131,067	230,121	358,164	719,352		719,352	(152,747)	566,605			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,827,475	981,081	3,362,550	9,171,106		9,171,106	(680,988)	8,490,118			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(55,843)	30		9
10	Interest and Other Investment Income	(30,626)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(257)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(597)	20		19
20	Contributions	(3,370)	20		20
21	Owner or Key-Man Insurance	(3,521)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,930)	21		24
25	Fund Raising, Advertising and Promotional	(27,204)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,575)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,696)	20		28
29	Other-Attach Schedule	(208,144)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (385,763)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(295,225)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (295,225)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (680,988)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
SHERIDAN HEALTH CARE CENTER

ID# 0027680
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COST-ADULT DAY CARE	$ (2,463)	43	1
2	VENDING INCOME	(5,846)	41	2
3	DAY PROGRAM EXPENSE	(1,126)	43	3
4	VETERANS LAB EXPENSE	(1,236)	10	4
5	VETERANS PHYSICIAN CHARGES	(2,707)	10	5
6	AMORTIZATION	(6,373)	36	6
7	ADULT DAY CARE SALARIES	(87,725)	43	7
8	ICLTC COPE DUES	(4,861)	20	8
9	2002 SEMINARS ADJ ON PRIOR YEAR REP.	580	24	9
10	TRUST FEES	(150)	20	10
11	2001 SEMINAR	(20)	24	11
12	2003 SEMINAR	(558)	24	12
13	MARKETING SEMINAR	(398)	24	13
14	ADULT DAY CARE SEMINAR	(85)	24	14
15	PPA-OFFICE	(7,400)	21	15
16	PPA-OT	(5,173)	39	16
17	PPA-PT	(6,272)	39	17
18	PPA-ST	(430)	39	18
19	CAPITALIZED R&M	(32,189)	06	19
20	MARKETING SALARY	(43,342)	43	20
21	NON-ALLOWABLE AUTO	(370)	43	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(208,144)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(257)											(257)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(32,189)											(32,189)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(32,446)											(32,446)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,943)											(3,943)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(3,943)											(3,943)	16
	C. General Administration													
17	Administrative			(160,030)		(31,623)	(107,285)						(298,937)	17
18	Directors Fees													18
19	Professional Services													19
20	Fees, Subscriptions & Promotions	(48,878)											(48,878)	20
21	Clerical & General Office Expenses	(50,905)											(50,905)	21
22	Employee Benefits & Payroll Taxes	(3,521)											(3,521)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(481)											(481)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			3,476			237						3,713	27
28	**TOTAL General Administration**	(103,785)		(156,554)		(31,623)	(107,048)						(399,010)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(140,174)		(156,554)		(31,623)	(107,048)						(435,399)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(55,843)											(55,843)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,626)											(30,626)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(6,373)											(6,373)	36
37	**TOTAL Ownership**	(92,842)											(92,842)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(11,875)											(11,875)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(5,846)											(5,846)	41
42	Provider Participation Fee													42
43	Other (specify):*	(135,026)											(135,026)	43
44	**TOTAL Special Cost Centers**	(152,747)											(152,747)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(385,763)		(156,554)		(31,623)	(107,048)						(680,988)	45

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 83,082	$ 83,082	15
16	V	27	PAYROLL TAXES				3,476	3,476	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MNGMNT. FEES - PRO HEALTH	131,612				(131,612)	23
24	V	17	MNGMNT. FEES - PRO HEALTH	111,500				(111,500)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 243,112			$ 86,558	$ * (156,554)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	360,000	SHA, LTD.	100.00%		$ (360,000)	15
16	V	17	M. FEES - FINN CONS.				114,194	114,194	16
17	V	17	M. FEES - PRO HEALTH				131,612	131,612	17
18	V	17	M. FEES - SHABAT & ASSOC.				114,194	114,194	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 360,000			$ 360,000	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - J. FINN	$	FINN CONSULTING, INC.	100.00%	$ 82,571	$ 82,571	15
16	V	27	PAYROLL TAXES						16
17	V								17
18	V	17	MANAGEMENT FEES	114,194				(114,194)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 114,194			$ 82,571	$ * (31,623)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - RON SHABAT	$	SHABAT & ASSOCIATES	100.00%	$ 6,909	$ 6,909	15
16	V	27	PAYROLL TAXES				237	237	16
17	V								17
18	V	17	MANAGEMENT FEES	114,194				(114,194)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 114,194			$ 7,146	$ * (107,048)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STANTON ARON	PARTNER	MANAGEMENT	16.31%	SEE ATTACHED	22	33.84%	Alloc. Pro He	$ 83,082	17-7	1
2	JACK FINN	PARTNER	MGMT. CONS.	9.32%	SEE ATTACHED	17	48.57%	Alloc. Finn C	82,571	17-7	2
3	RONALD SHABAT	PARTNER	MGMT. CONS.	15.04%	SEE ATTACHED	2	3.64%	Alloc. Shabat	6,909	17-7	3
4	NANJEAN PAINTER	PARTNER	MANAGEMENT	1.75%	SEE ATTACHED	40	80.00%	Social Svc	127,448	12-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 300,010		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HRS WORKED	51	4	$ 192,600	$ 192,600	22	$ 83,082	1
2	27	PAYROLL TAXES	AVG. HRS WORKED	51	4	8,057		22	3,476	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 200,657	$ 192,600		$ 86,558	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHA, LTD. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: ((847)236-1111
Fax Number: ((847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	M. FEES - FINN CONS.	DIRECT ALLOC	1	1	114,194		1	114,194	1
2	17	M. FEES - PRO HEALTH	DIRECT ALLOC	1	1	131,612		1	131,612	2
3	17	M. FEES - SHABAT & ASSOC.	DIRECT ALLOC	1	1	114,194		1	114,194	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 360,000	$		$ 360,000	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FINN CONSULTING INC.
Street Address: 2901 W. COYLE
City / State / Zip Code: CHICAGO, IL 60645
Phone Number: ((773)764-3466
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - J. FINN	AVG. HRS WORKED	35	2	$ 170,000	$ 170,000	17	82,571	1
2	27	PAYROLL TAXES	AVG. HRS WORKED	35	2			17		2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 170,000	$ 170,000		$ 82,571	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHABAT & ASSOCIATES
Street Address: 7514 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847)982-1195
Fax Number: ((847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - RON SHABAT	AVG. HRS WORKED	55	11	190,000	190,000	2	6,909	1
2	27	PAYROLL TAXES	AVG. HRS WORKED	55	11	6,506		2	237	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 196,506	$ 190,000		$ 7,146	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MANUFACTURERS BANK		X	MORTGAGE	$46,648.00	09/28/98	$ 4,500,000	$ 3,346,853	9/08	7.04%	$ 248,980	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	LINE OF CREDIT	VARIOUS	07/10/94	1,700,000	748,000	07/10/05	5.00%	17,765	6
7												7
8												8
9	TOTAL Facility Related				$46,648.00		$ 6,200,000	$ 4,094,853			$ 266,745	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	INTEREST INCOME										(30,626)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (30,626)	14
15	TOTALS (line 9+line14)						$ 6,200,000	$ 4,094,853			$ 236,119	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 168,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 188,807	2
3. Under or (over) accrual (line 2 minus line 1).		$ 20,807	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 198,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 218,807	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	146,705	8
	1998	146,210	9
	1999	150,301	10
	2000	160,170	11
	2001	188,807	12

2001 TAX x 1.05 = CURRENT YEAR ACCRUAL
188807 X 1.05 = 198000 (ROUNDED)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHERIDAN HEALTH CARE CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-22-301-007	LONG TERM CARE PROPERTY	$ 181,052.80	$ 181,052.80
2.	04-22-301-009	LONG TERM CARE PROPERTY	$ 7,753.98	$ 7,753.98
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 188,806.78	$ 188,806.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHERIDAN HEALTH CARE CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ADULT DAY CARE - 860 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	50,091	1990	$ 28,460	1
2					2
3	TOTALS	50,091		$ 28,460	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1990	$ 5,384,307	$ 170,930	35	$ 153,837	$ (17,093)	$ 1,987,061	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	5,655		20	-		5,655	9
10	Various			1981	13,906		20	-		13,906	10
11	Various			1982	1,171		20	-		1,171	11
12	Various			1983	17,000		20	-		16,819	12
13	Various			1984	36,737		20	-		36,737	13
14	Various			1985	135,882		20	5,984	5,984	125,242	14
15	Various			1986	63,852		20	3,361	3,361	55,457	15
16	Various			1987	60,439		20	3,021	3,021	47,047	16
17	Various			1988	24,257		20	1,212	1,212	17,574	17
18	Various			1989	102,083		20	5,420	5,420	84,195	18
19	Various			1990	84,998		20	4,250	4,250	54,397	19
20	Various			1991	10,496		20	526	526	6,202	20
21	Various			1992	18,109		20	889	889	9,487	21
22	Various			1993	39,981		20	1,999	1,999	19,340	22
23	Various			1994	123,996		20	6,203	6,203	53,229	23
24	Various			1995	157,007		20	7,851	7,851	61,019	24
25	Various			1996	210,423		20	10,523	10,523	67,162	25
26	Various			1997	97,938		20	4,898	4,898	27,389	26
27	Various			1998	76,538		20	3,828	3,828	17,414	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation			62,126			(62,126)		69
70	TOTAL (lines 4 thru 69)		$ 6,664,775	$ 233,056		$ 213,802	$ (19,254)	$ 2,706,503	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,664,775	$ 233,056		$ 213,802	$ (19,254)	$ 2,706,503	1
2	DINING RM RENOVATION	1999	700		20	35	35	131	2
3	DINING RM RENOVATION	1999	5,000		20	250	250	938	3
4	SOUTH FENCE	1999	2,445		20	122	122	458	4
5	PENTHOUSE - LTC	1999	26,615		20	1,331	1,331	4,991	5
6	INSULATED GLASS	1999	525		20	26	26	104	6
7	PUMP MOTOR	1999	3,855		20	193	193	772	7
8	INFRARED DOOR	1999	3,200		20	160	160	627	8
9	WATER HEATER	1999	12,792		20	640	640	2,453	9
10	FENCING	1999	2,845		20	142	142	556	10
11	BORDERS	1999	2,336		20	117	117	458	11
12	CARPETING	1999	1,943		20	97	97	356	12
13	COVE BASE	1999	576		20	29	29	106	13
14	FLOOR TILES	1999	4,691		20	235	235	862	14
15	VINYL FLOOR	1999	2,752		20	138	138	506	15
16	HANDRAILS	1999	1,042		20	52	52	186	16
17	REPLACE PIPING	1999	2,787		20	139	139	521	17
18	FREEZER REPAIR	1999	2,297		20	115	115	431	18
19	PENTHSE/LOB HVAC RPR	1999	12,511		20	626	626	2,243	19
20	INSULATE PIPES	1999	1,875		20	94	94	345	20
21	COUNTER SEAT	1999	1,242		20	62	62	222	21
22	VCT INSTALLATIO	1999	5,483		20	274	274	982	22
23	WALLPAPER	1999	3,374		20	169	169	606	23
24	WALLPAPER	1999	691		20	35	35	125	24
25	CORNER GUARD	1999	58		20	3	3	11	25
26	FLOOR TILES	1999	60		20	3	3	11	26
27	CORNER GUARD	1999	58		20	3	3	11	27
28	FLOORING	1999	10,690		20	535	535	1,873	28
29	PENTHOUSE - JJ'S	1999	25,000		20	1,250	1,250	4,583	29
30	HVAC REPAIRS	1999	4,116		20	206	206	755	30
31	RENOVATION - JJ'S	1999	15,000		20	750	750	2,625	31
32	RUBBER TILE	1999	402		20	20	20	68	32
33	BUMPER/HANDRAIL	1999	517		20	26	26	89	33
34	TOTAL (lines 1 thru 33)		$ 6,822,253	$ 233,056		$ 221,679	$ (11,377)	$ 2,735,508	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,822,253	$ 233,056		$ 221,679	$ (11,377)	$ 2,735,508	1
2	BORDERS	1999	405		20	20	20	68	2
3	THE GLASS CUTTER	1999	2,659		20	133	133	477	3
4	KOSCO FLAGS & POLES	1999	1,664		20	83	83	277	4
5	BASE/FLOOR PATCHING	1999	1,008		20	50	50	167	5
6	REMODEL STORAGE ROOM	1999	4,000		20	200	200	683	6
7	DOORS	1999	489		20	24	24	82	7
8	PENTHOUSE - JJ'S	1999	5,000		20	250	250	854	8
9	RENOVATION - LTC	1999	30,000		20	1,500	1,500	5,125	9
10	HEATER VENTS	1999	535		20	27	27	92	10
11	REMODEL STORAGE RM	1999	10,000		20	500	500	1,708	11
12	HANDRAILS	1999	824		20	41	41	137	12
13	CAR PORT REPAIRS	1999	2,250		20	113	113	377	13
14	DINING ROOM RENOVATI	1999	(2,150)		20	(108)	(108)	(396)	14
15	REMODEL STORAGE ROOM	1999	4,300		20	215	215	717	15
16	FIRE DOOR	1999	3,719		20	186	186	605	16
17	FLOOR TILES	1999	302		20	15	15	49	17
18	DRYWALL	1999	2,629		20	131	131	448	18
19	SHOWER ROOM REPAIRS	1999	750		20	38	38	124	19
20	PENTHOUSE - JJ'S	1999	4,160		20	208	208	676	20
21	PATCH HOLES	1999	1,168		20	58	58	179	21
22	ROLLER SHADES	1999	2,148		20	107	107	339	22
23	FIRE DOOR	1999	3,719		20	186	186	605	23
24	ARCHITECT'S FEES	1999	7,860		20	393	393	786	24
25	FIRE DOOR 4TH FLR SO	2000	4,038		20	202	202	606	25
26	FIRE DOOR 4THFLR NOR	2000	4,038		20	202	202	606	26
27	DOORS - BREAKROOM	2000	923		20	46	46	138	27
28	DOWN PAYMENT - WALLS	2000	5,550		20	278	278	811	28
29	DAYCARE CTR ARCHITEC	2000	787		20	39	39	114	29
30	ARCHITECT FEES	2000	6,140		20	307	307	921	30
31	ARCHITECT - DEMENTIA	2000	752		20	38	38	111	31
32	GLASS ALUM DOOR	2000	800		20	40	40	117	32
33	ELECTRICAL WORK	2000	1,440		20	72	72	216	33
34	TOTAL (lines 1 thru 33)		$ 6,934,160	$ 233,056		$ 227,273	$ (5,783)	$ 2,753,327	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,934,160	$ 233,056		$ 227,273	$ (5,783)	$ 2,753,327	1
2	WINDOW/LIGHT FIXTURE	2000	3,980		20	199	199	564	2
3	MAIN DINING RM 4THFL	2000	5,630		20	282	282	823	3
4	ARCHITECT - DEMENTIA	2000	269		20	13	13	38	4
5	CHAIR RAILING	2000	1,884		20	94	94	259	5
6	HANDRAILS	2000	1,453		20	73	73	207	6
7	ELECTRICAL SOCKETS	2000	1,826		20	91	91	250	7
8	DOORS - REHAB DEPT	2000	600		20	30	30	83	8
9	DOORS	2000	2,704		20	135	135	360	9
10	WALLPAPER	2000	824		20	41	41	106	10
11	WALLPAPER	2000	1,826		20	91	91	243	11
12	PIPING	2000	4,552		20	228	228	608	12
13	INSTALL FAUCETS	2000	3,925		20	196	196	506	13
14	WALLPAPER	2000	1,988		20	99	99	256	14
15	CORNER GUARDS	2000	652		20	33	33	85	15
16	WALLCOVERING	2000	153		20	8	8	20	16
17	WALLPAPER	2000	1,000		20	50	50	125	17
18	WALLGUARD	2000	883		20	44	44	110	18
19	FIRE DOOR	2000	4,130		20	207	207	500	19
20	WALLPAPER	2000	666		20	33	33	80	20
21	WALLCOVERING	2000	632		20	32	32	80	21
22	TRAC LIGHTING	2000	671		20	34	34	82	22
23	WINDOW TREATMENTS	2000	618		20	31	31	72	23
24	METAL DOOR	2000	1,010		20	51	51	119	24
25	CARPET	2000	1,354		20	68	68	159	25
26	SHADES	2000	2,666		20	133	133	310	26
27	FIRE DOOR	2000	4,137		20	207	207	466	27
28	WALL GUARD	2000	636		20	32	32	72	28
29	HINGE/LOCK/DEADBOLT	2000	656		20	33	33	72	29
30	TILE	2000	703		20	35	35	70	30
31	ARCHITECT'S FEE	2000	573		20	29	29	58	31
32	MOTOR	2000	1,288		20	64	64	128	32
33	GENERATOR CIRCUIT	2000	1,159		20	58	58	116	33
34	TOTAL (lines 1 thru 33)		$ 6,989,208	$ 233,056		$ 230,027	$ (3,029)	$ 2,760,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,989,208	$ 233,056		$ 230,027	$ (3,029)	$ 2,760,354	1
2	COMPRESSOR CONTROLS	2000	2,448		20	122	122	244	2
3	TEMPERATURE CONTROLS	2000	2,666		20	133	133	266	3
4	HOT WATER BOILER	2000	602		20	30	30	60	4
5	CHILLER	2000	7,414		20	371	371	742	5
6	ALLEY LIGHTS	2000	504		20	25	25	50	6
7	3RD FLR CORNICES	2000	598		20			598	7
8	CUBICLE CURTAINS	2000	1,950		20	98	98	229	8
9	FIRE DOOR & INSTALL	2001	4,000		20	200	200	400	9
10	DOOR REPLACEMENT	2001	5,425		20	271	271	519	10
11	CORNICES & VALANCES	2001	2,455		20	123	123	246	11
12	WINDOW TREATMENT	2001	2,162		20	108	108	207	12
13	WALLCOVERING	2001	1,782		20	89	89	171	13
14	WALLCOVERING	2001	2,217		20	111	111	204	14
15	REMODELING	2001	8,000		20	400	400	700	15
16	FIRE PANEL	2001	605		20	30	30	53	16
17	REMODELING	2001	2,780		20	139	139	243	17
18	FIRE INSULATION	2001	546		20	27	27	45	18
19	ELECTRIC CIRCUIT	2001	230		20	12	12	20	19
20	REMODELING/DRYWALL	2001	3,286		20	164	164	301	20
21	FIRE DAMPERS	2001	9,779		20	489	489	815	21
22	BIRCH DOORS	2001	2,616		20	131	131	207	22
23	FLOORS	2001	1,883		20	94	94	149	23
24	WALLPAPER	2001	1,358		20	68	68	108	24
25	REFRIGERATION LINES	2001	10,203		20	510	510	808	25
26	WOODEN PLANTERS	2001	200		20	10	10	16	26
27	REFRIGERATION LINES	2001	10,204		20	510	510	808	27
28	PULL STATION PROTECT	2001	1,163		20	58	58	92	28
29	ROOM SIGN	2001	745		20	75	75	113	29
30	HANDRAIL	2001	1,955		20	98	98	147	30
31	ELECTRICAL CIRCUITS	2001	2,198		20	110	110	165	31
32	REFRIGERATION LINES	2001	4,689		20	234	234	351	32
33	FIRE DAMPER	2001	616		20	31	31	47	33
34	TOTAL (lines 1 thru 33)		$ 7,086,487	$ 233,056		$ 234,898	$ 1,842	$ 2,769,478	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 7,086,487	$ 233,056		$ 234,898	$ 1,842	$ 2,769,478	1
2	BOILER	2001	743		20	37	37	56	2
3	WALLPAPER	2001	4,243		20	212	212	283	3
4	RENOVATIONS	2001	1,900		20	95	95	119	4
5	MOSAIC/GROUT	2001	800		20	21	21	25	5
6	UPHOLSTED CORNICES	2001	769		20	38	38	48	6
7	CEMENT	2001	383		20	19	19	22	7
8	SOLAR SHADES	2001	4,028		20	403	403	470	8
9	ROOF INSULATION	2001	5,950		20	298	298	348	9
10	HANDRAIL/VINYL FLOOR	2001	6,519		20	326	326	353	10
11	WALLPAPER	2001	1,537		20	77	77	83	11
12	RECIPROCAL CHIILER	2001	4,576		20	229	229	248	12
13	CENTRAL AIR BLOWER	2001	1,192		20	60	60	105	13
14	FIRE DAMPERS	2001	9,103		20	455	455	796	14
15	PADDING	2001	908		20	45	45	64	15
16	APARTMENT COMPACTOR	2001	9,830		20	492	492	697	16
17	WALLPAPER	2001	2,905		20	145	145	205	17
18	DRAIN WORK	2001	1,794		20	194	194	194	18
19	FIRE DAMPERS	2001	2,133		20	116	116	116	19
20	COIL REPAIRS	2001	1,605		20	87	87	87	20
21	MOTOR	2001	705		20	38	38	38	21
22	LANDSCAPING	2001	925		20	50	50	50	22
23	COMPRESSOR REPAIRS	2001	4,255		20	230	230	230	23
24	DOOR EDGES	2002	4,091		20	409	409	409	24
25	AMP BOX	2002	802		20	80	80	80	25
26	SHADES	2002	10,131		20	844	844	844	26
27	DOORS	2002	861		20	72	72	72	27
28	BOILER	2002	7,883		20	547	547	547	28
29	PERGO FLOOR	2002	2,054		20	103	103	103	29
30	GENERATOR	2002	8,200		20	781	781	781	30
31	FLOORING	2002	449		20	20	20	20	31
32	WATER HEATER	2002	7,602		20	422	422	422	32
33	DOOR & FRAME	2002	1,651		20	110	110	110	33
34	TOTAL (lines 1 thru 33)		$ 7,197,014	$ 233,056		$ 241,953	$ 8,897	$ 2,777,503	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 7,197,014	$ 233,056		$ 241,953	$ 8,897	$ 2,777,503	1
2	COMPRESSOR	2002	12,526		20	895	895	895	2
3	MEDICAL OFFICE	2002	44,200		20	2,210	2,210	2,210	3
4	BATHROOM	2002	1,306		20	36	36	36	4
5	ARCHITECT FEE	2002	6,000		20	38	38	38	5
6	CEMENT CURB	2002	895		20	22	22	22	6
7	LANDSCAPING/CURBS	2002	2,536		20	42	42	42	7
8	BURNERS	2002	8,395		20	105	105	105	8
9	WINDOW TREATMENT	2002	944		20	87	87	87	9
10	SMOKE ALARMS	2002	792		20	66	66	66	10
11	WINDOW COVERINGS	2002	3,477		20	58	58	58	11
12	WALLPAPER DINING ROOM	2002	1,447		20	72	72	72	12
13	WALLPAPER RESIDENT ROOMS	2002	3,053		20	153	153	153	13
14	WALLPAPER OFFICES	2002	927		20	46	46	46	14
15	WALLPAPER BREAKROOMS	2002	1,252		20	63	63	63	15
16	WALLPAPER OFFICE/BREAKROOM	2002	1,949		20	97	97	97	16
17	PAINITNG	2002	4,000		20	200	200	200	17
18	PAINITNG	2002	4,000		20	200	200	200	18
19	WALLPAPER 3RD FLOOR	2002	5,212		20	261	261	261	19
20	FLOOR SWITCH REPAIRS	2002	575		20	29	29	29	20
21	HEATER REPAIRS	2002	758		20	38	38	38	21
22	WATER HEATER REPAIRS	2002	2,228		20	111	111	111	22
23	PILOT SAFETY VALVE INSTALLATION	2002	2,070		20	104	104	104	23
24	ELEVATOR REPAIRS	2002	1,104		20	55	55	55	24
25	ELEVATOR REPAIRS	2002	2,173		20	109	109	109	25
26	BOILER REPAIRS	2002	1,441		20	72	72	72	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,310,274	$ 233,056		$ 247,121	$ 14,065	$ 2,782,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 708,576	$ 78,488	$ 61,748	$ (16,740)	10	$ 401,024	71
72	Current Year Purchases	145,817	65,450	12,282	(53,168)	10	12,282	72
73	Fully Depreciated Assets	436,964				10	436,964	73
74								74
75	TOTALS	$ 1,291,357	$ 143,938	$ 74,030	$ (69,908)		$ 850,270	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,630,091	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 376,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 321,151	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (55,843)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,632,941	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND - 1994	$ 199,000	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 199,000	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	ROOF AND FAÇADE	$ 125,145	92
93			93
94			94
95		$ 125,145	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 23,279 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	DODGE VAN	$ 456	$ 5,467	17
18	ADMINISTRATIVE		685	8,220	18
19					19
20					20
21	TOTAL		$ 1,141	$ 13,687	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 338	$ 312	$	$ 650
2	Books and Supplies	744	687		1,431
3	Classroom Wages (a)		9,749		9,749
4	Clinical Wages (b)		4,642		4,642
5	In-House Trainer Wages (c)		14,346		14,346
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 1,082	$ 29,736	$	$ 30,818
10	SUM OF line 9, col. 1 and 2 (e)	$ 30,818			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 693

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	13
2. From other facilities (f)	
TOTAL TRAINED	25

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 92,649	$		$ 92,649	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,477			4,477	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			94,614			94,614	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				171,182		171,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					2,692	58,939		61,631	13
14	TOTAL			$		$ 194,432	$ 230,121		$ 424,553	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 468,627	$	1
2	Cash-Patient Deposits	129,914		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,862,485		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	986,209		5
6	Prepaid Insurance	91,707		6
7	Other Prepaid Expenses	11,897		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	177,941		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,728,780	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	227,460		13
14	Buildings, at Historical Cost	5,384,307		14
15	Leasehold Improvements, at Historical Cost	1,728,912		15
16	Equipment, at Historical Cost	1,328,485		16
17	Accumulated Depreciation (book methods)	(3,812,363)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	176,128		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,032,929	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,761,709	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 388,489	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	142,673		28
29	Short-Term Notes Payable	748,000		29
30	Accrued Salaries Payable	234,112		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,886		31
32	Accrued Real Estate Taxes(Sch.IX-B)	198,000		32
33	Accrued Interest Payable	20,295		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	863		35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,750,318	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,346,853		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,346,853	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,097,171	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,664,538	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,761,709	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,732,925	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,732,925	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	88,913	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(157,300)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (68,387)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,664,538	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,605,147	1
2	Discounts and Allowances for all Levels	57,901	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,663,048	3
	B. Ancillary Revenue		
4	Day Care	49,110	4
5	Other Care for Outpatients		5
6	Therapy	356,657	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 405,767	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	693	11
12	Gift and Coffee Shop	6,591	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,421	19
20	Radiology and X-Ray		20
21	Other Medical Services	141,873	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 160,578	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,626	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,626	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,260,019	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,889,459	31
32	Health Care	3,626,112	32
33	General Administration	2,030,298	33
	B. Capital Expense		
34	Ownership	905,885	34
	C. Ancillary Expense		
35	Special Cost Centers	565,425	35
36	Provider Participation Fee	153,927	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,171,106	40
41	**Income before Income Taxes (line 30 minus line 40)****	88,913	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 88,913	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,650	$ 62,303	$ 23.51	1
2	Assistant Director of Nursing	4,024	4,338	114,606	26.42	2
3	Registered Nurses	17,897	19,377	450,001	23.22	3
4	Licensed Practical Nurses	26,025	28,566	705,135	24.68	4
5	Nurse Aides & Orderlies	134,587	143,476	1,320,738	9.21	5
6	Nurse Aide Trainees	1,488	1,488	28,737	19.31	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,696	8,677	86,152	9.93	8
9	Activity Director					9
10	Activity Assistants	10,332	11,136	105,848	9.51	10
11	Social Service Workers	26,346	28,086	413,428	14.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,389	36,262	317,544	8.76	15
16	Dishwashers					16
17	Maintenance Workers	16,977	19,011	208,362	10.96	17
18	Housekeepers	31,498	34,493	304,385	8.82	18
19	Laundry	16,243	18,063	173,239	9.59	19
20	Administrator	2,080	2,199	115,539	52.54	20
21	Assistant Administrator	2,080	2,112	54,221	25.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,852	8,355	176,078	21.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,585	4,081	60,092	14.72	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	7,703	8,312	131,067	15.77	33
34	TOTAL (lines 1 - 33)	351,882	380,682	$ 4,827,475 *	$ 12.68	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 10,196	01-03	35
36	Medical Director	MONTHLY	18,526	09-03	36
37	Medical Records Consultant	MONTHLY	2,752	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	4,800	10-03	39
40	Physical Therapy Consultant	MONTHLY	10,238	10a-03	40
41	Occupational Therapy Consultant	MONTHLY	16,413	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	MONTHLY	1,548	11-03	44
45	Social Service Consultant	MONTHLY	6,146	12-03	45
46	Other(specify)				46
47	URB CONSULTANT	MONTHLY	1,030	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 71,649		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	748	$ 33,628	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	748	$ 33,628		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARLA BENSON	ADMINISTRATOR	0.00	$ 115,539
ROSS ZELLER	ASST. ADMIN	0.00	54,221
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,760

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - SHA, LTD.	$ 360,000
PRO HEALTH ADMINISTRATIVE FEES	111,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 471,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	ACCOUNTING	$ 49,419
PAYCHEX	DATA PROCESSING	7,617
BISYS	DATA PROCESSING	5,456
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	4,678
STEVEN ELSTER	COMPUTER CONSULTANT	3,405
EVAN HOLLANDER	COMPUTER CONSULTANT	5,569
ACCUMED	COMPUTER CONSULTANT	2,075
JACOBS HEALTHCARE	COMPUTER CONSULTANT	1,800
SLS	COMPUTER CONSULTANT	6,859
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 86,878

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,217
Unemployment Compensation Insurance	30,133
FICA Taxes	360,984
Employee Health Insurance	190,261
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	9,389
TOTAL (agree to Schedule V, line 22, col.8)	$ 720,984

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,103
Health Care Worker Background Check	3,500
(Indicate # of checks performed 500)	
ICLTC DUES	7,082
DUES	690
LICENSES AND FEES	1,729
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,104

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,518
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,518

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN HEALTH CARE CENTER # 0027680 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $12,663**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,799** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **153,927**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees